Eastern Health Collaborative (RC)

10/12/2017
12:00pm-1:30pm
EIPH Conference Room

Attendees: Dr. Boyd Southwick, Dr. George Groberg, Geri Rackow, James Corbett, Corinne Torgesen, Nicole Foster, Alisha Tueller, Amanda Birch, Amy Myler, Ashlee Carlson, Bryce Bond, Dr. Chad Horrocks, Charlotte Fatafehi (phone), Eric Gravatt, Janae Larsen, Jaylee Packer, Julie Woolstenhulme, Dr. Kelly Anderson, Laurel Ricks, Lyndsey Floyd, Michelle Tueller, Michael Ryan, Natalee Snarr, Stephen Hickman, Tom Tueller, Von Crofts, Wendy Swope, NP-C, Molly Volk, Chelsea Stevenson, Madeline Russell, and Ann Watkins

Welcome by: James Corbett at 12:05pm

Minutes

Agenda Item:	PCMH Transformation- Care Coordination and Care Transitions Presentation
Presenter:	Charlotte Fatafehi, Grand Peaks Medical

Discussion:

Charlotte shared how their clinics have implemented care coordination and how she as care coordinator identifies and contacts patients for coordination and care plans. She checks their schedule from the previous day to identify patients who qualify, and drafts a care plan based on what was discussed with the provider. She has been measuring the effectiveness of this method and determined it was only semi-effective. She began a new process, using E-Clinical to sort labs done on the previous day instead of looking at reason for a patient's visit. She drafts the care plan and calls patients 2-3 days after their appointment to complete the care plan. A copy of the care plan is mailed to all care coordination patients. She puts a flag in the EMR in patient charts when they need follow-up tasks completed. The clinic schedule also has a Care Coordinator "provider" spot that Charlotte uses to remind herself when she needs to follow-up with patients. Her notes are charted in the preventive notes section and she creates a phone encounter for all contact she makes with the patients.

Agenda Item:	PCMH Transformation- Team-Based Care and Practice Organization Presentation
Presenter:	Von Crofts, Rocky Mountain Diabetes Center

Discussion:

Von shared how their clinic has taken a team approach to PCMH transformation and clinic quality improvement. They utilize team members who represent many departments in the clinic. They started as the PCMH team, and are now called the Quality Improvement (QI) Committee. They have representation from management, nursing, care coordination, education, and SHIP QI Staff. They do not have regular attendance from a provider, but Von meets weekly with all providers and serves as the liaison between the providers and the QI Committee. He shares information both directions. A challenge they have faced has been with identification of being a specialty practice vs. primary care. They have recently switched from pursuing PCMH recognition to pursuing PCSP (Patient-Centered Specialty Practice) recognition.

Agenda Item:	PCMH Transformation- Team-Based Care and Practice Organization Presentation
Presenter:	Alisha Tueller and Lyndsey Floyd, Unified Healthcare and Tueller Counseling

Discussion:

Unified Healthcare and Tueller Counseling have a unique set up since they have Behavioral Health and Primary Care clinics together. They meet weekly to makes sure both clinics are on the same page. Patients receive information about the services provided at both clinics and their responsibilities as a patient through the new patient brochure. They offer case management on the Behavioral Health side and care coordination on the Primary Care side. They coordinate care plans with the case management manager (Stacey) on the Behavioral Health side, and the two care coordinators (Alisha and Lisa) who split up the coordination for primary care patients into behavioral health and primary care to make sure it all works together. They also have daily huddles that help them stay on the same page. Frequent communication has been key to successful coordination.

Agenda Item:	PCMH Transformation- Knowing and Managing Your Patients Presentation
Presenter:	Wendy Swope, NP-C, Southfork Medical Clinic

Discussion:

Wendy has been utilizing reports from her EMR to create patient registries based on diagnoses, and to pinpoint certain populations for measures. Occasionally she faced a barrier when she created custom fields for certain measures, because they won't pull as structured data. She started utilizing a different system to help pull structured data for patients with Hypertension and Diabetes. This has been an effective way to help her manage those patients and remind them of preventive tests, follow-up appointments, and so forth. She recommends calling the EMR service and continue calling until the clinic's questions are answered and looking for online assistance like videos.

Agenda Item:	PCMH Transformation- Care Management and Support Presentation
Presenter:	Julie Woolstenhulme, Driggs and Victor Health Clinics

Discussion:

Julie explained how their clinics implemented care coordination through the Chronic Care Management (CCM) program. She started with just a few patients, and now her registry has grown to around 40 patients. She has tailored the coordination to the needs of each patient and has found that each clinic does care coordination differently. This is okay, because the needs of each clinic and their patients are different. They have found value in having a care coordinator be an extender of the provider to keep track of patients, follow up, and remind them of needed services. Julie regularly communicates with the providers about their patients. Many providers have commented that care coordination saves them time. The foundation of care coordination has been developing relationships with the patients and finding at least one thing they already do well. They have seen many improvements in their CCM patients and Julie shared three success stories. Their EMR has been a barrier because it did not have good resources and tools for care coordination. They recently added Dulcian, a program that helps with care coordination and care plans.

Agenda Item:	PCMH Transformation- Performance Measurement and Quality Improvement Presentation
Presenter:	Michael Ryan, Bingham Memorial

Discussion:

Mike shared an overview set up of the quality improvement concept and explained how each criteria in the concept build upon each other. As an organization, they picked four measures for their clinics to work on (Depression Screening, Pneumonia Vaccine, Colonoscopies, and Diabetes). Mike pulls data on a monthly basis and

shares the results during staff meeting. An emoji pillow award goes to the clinic with the best scores in each category that month. If a clinic achieves the top score for additional months, they receive another award like a lunch coupon. Each clinic's staff creates a PDSA cycle to implement as an effort to make an improvement in the measures for the next month. So far, they have seen great participation and improvement in measures from the clinics. Mike talked about the importance of validating and checking the data. It is important to make sure the numbers are correct before sharing the information with providers and other stakeholders. They will not trust the data if it is inaccurate.

AGENDA ITEM:	Health Outcomes- Aggregate Rates-Clinical Quality Measures
PRESENTER:	James Corbett, EIPH

DISCUSSION:

James shared the aggregate data for the clinical quality measures (CQM) chosen by the group. He showed how our measures compare to the goals set for each measure. He also explained that pulling this data will help clinics ensure their data is being correctly extracted from their EMR.

AGENDA ITEM:	PCMH Transformation- Patient-Centered Access and Continuity Presentation
PRESENTER:	Corinne Torgesen, EIPH

DISCUSSION:

Corinne gave a brief presentation on the Core Criteria in the Access and Continuity (AC) NCQA Concept. She made clarifications on what NCQA is looking for with the evidence section and gave examples of how clinics can meet these requirements.

AGENDA ITEM:	Medical-Health Neighborhood, Additional Opportunities for Clinics
PRESENTER:	Madeline Russell, State SHIP Team

DISCUSSION:

Madeline shared upcoming opportunities that SHIP clinics can choose to participate in. There will be a Community Health Worker (CHW) training coming up. It is free to students. They are working with payers to have the work of CHW's acknowledged and reimbursable. We currently have nine Community Health EMS (CHEMS) programs across the state, including Idaho Falls Fire that can be utilized by clinics. In December, clinics can apply to become a Virtual PCMH if they use CHWs or CHEMS. If selected, they will receive a $2500 reimbursement. Project ECHO is coming up as a Telehealth concept that partners with the University of Idaho and their WAAMI program. The first section will start in January and will focus on the Opioid Crisis. They would like to use SHIP clinics as the spokes for this project. There are 25 spoke spots available. Additional information will be coming.

OTHER BUSINESS AND FUTURE AGENDA ITEMS:

Will be determined based on the results of the post-meeting survey

NEXT MEETING

DATE: 1/11/2018
TIME: 12:00pm-1:30pm
LOCATION: EIPH Conference Room